Request for Access to Protected Health Information

You have the right to inspect your protected health information in records, which Des Moines County Public Health creates or maintains. You also have the right to request copies of those records.

INDIVIDUAL INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
ID NUMBER:	DATE OF BIRTH:	
DAYTIME TELEPHONE NUMBER (REQUIRED):		
EMAIL ADDRESS:		

DIRECTIONS

Please read the following before completing this form. If any of the circumstances below applies to you, you may not need to fill out this form.

You have a personal injury case, and Des Moines County Public Health has paid for services related to the injury and you want information about these services and/or payments,

Or

You are requesting access to records on behalf of a deceased Des Moines County Public Health beneficiary in order to repay Des Moines County Public Health for services received by the deceased beneficiary. You may have received and Estate Recovery Questionnaire in the mail,

Or

You are involved in a worker's compensation case in which Des Moines County Public Health has paid for the services for the injury you received while on the job.

To continue with your request for access to your Des Moines County Public Health records, please go to page 2 and indicate which records you wish to get a copy of. Also, be sure to include the required information for verifying your identity and address.

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?	
☐ TREATMENT RECORDS, which include visit records, lab/test results, immunizations, medications orders, referrals, and treatment plans. ☐ TREATMENT AUTHORIZATION REQUEST SCREENS. Printouts contain patient names, which providers have requested services, which services were requested, the decision about the service(s), including a simple description of the decision,	Managed Care Records: ☐ Enrollment Records ☐ Disenrollment Records ☐ Capitation Paid to Health Plan Please contact your managed care plan if you want access to your medical records.

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

and whether the provider has billed for these services. ☐ CASE MANAGEMENT RECORDS, which contain case manager notes. ☐ CLAIM DETAIL REPORTS, which contain claims paid by Des Moines County Health Department for services received.	

I AM REQUESTING COPIES OF RECORDS FOR THE FOLLOWING DATES OF SERVICE

You must specify dates of service in order to get records.

FROM DATE (month/day/year)	TO DATE (month/day/year)

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION
☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON
☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NOTE: Any person or attorney may be named below. Records will not be sent to photocopy services.

NAME:

TELEPHONE NUMBER:

ADDRESS:

RELATIONSHIP TO YOU:

IDENTIFYING INFORMATION IS REQUIRED

ADDRESS VERIFICATION ATTACHED

Type: _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

COPY OF IDENTIFICATION ATTACHED

TYPE: _____ (STATE DRIVER'S LICENSE, STATE IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:_____

(IF NO IDENTIFICATION ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)
NOTARIZED BY: _____ ON _____ (DATE). NOTARY PUBLIC NUMBER_____
UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE DATE

_____ _____

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